RUTGERS
University Alumni Association

The United States Life Insurance Company in the City of New York

Application for Group Disability Income Insurance

Home Office: 175 Water Street, New York, NY 10038
(Herein called the Company)

1. Alumnus/Spouse information *(Please print or type):*

I am a ☐ Alumnus ☐ Spouse	If you are a spouse, name of alumnus	Age	Sex ☐ M ☐ F
Name (First, Middle, Last)			
Billing Address			
City	State	ZIP	
Date of Birth (MM/DD/YY)	Place of Birth	Height (ft./in.)	Weight (lbs.)
Social Security No.	Preferred Phone No.	Email Address	
Name and Address of Applicant's Physician			
Are you now, and have you been for the last 30 days, performing all of the duties of your regular occupation for at least 30 hours per week for your present employer?			☐ YES ☐ NO
Employer Name and Address			
Occupation	Date of Hire (MM/DD/YY)	Annual Earned Income (after business expenses) $	

2. Disability insurance requested:

Waiting Period: ☐ 90-day ☐ 60-day

Monthly Benefit:

☐ $3,000 ☐ $2,500 ☐ $2,000 ☐ $1,500 ☐ $1,000 ☐ Other $ _____

($1,000 – $3,000, not to exceed 50% of your basic monthly pay)

Note: The monthly benefit amount is based upon your Annual Earned Income (after business expenses).

Benefit Period: ☑ 5-year

The Certificate may contain a provision regarding the benefits paid for "pre-existing conditions" and the applicable limitations. Pre-existing condition means any injury or sickness within 12 months before you were insured for which you: 1. incurred charges, 2. received medical treatment, consultation, care, or services, including diagnostic measures, 3. took prescribed drugs or medicines. There is a *Waiting Period* for benefits. No benefits will be paid until you have been continually insured for 12 months. The pre-existing condition waiting period and the *Waiting Period* are satisfied concurrently from the date of disability.

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3. I wish to pay:

☑ Semi-annual Direct Bill

4. Please answer these brief questions:

To the best of your knowledge and belief:

1. Have you ever had, been diagnosed with, or been treated for: chest pain; disease or disorder of the heart, liver, kidneys, blood or lungs; high blood pressure; stroke or other neurological disorder; mental/nervous disorder; drug or alcohol abuse; diabetes; cancer or tumor; arthritis or other musculoskeletal disease or disorder; Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for an immune disorder excluding HIV?

   ☐ YES ☐ NO

2. **Other than stated above,** have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, for any reason?

   ☐ YES ☐ NO

3. Are you now taking prescription medication or receiving medical attention?

   ☐ YES ☐ NO

For "Yes" answers to questions 1–3 above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes" in the box at the right. ☐ YES ☐ NO

Question #	Condition	Date Occurred	Duration	Degree of Recovery	Name and Address of Physicians, Hospitals or Clinics Consulted

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5. Existing and pending insurance section:

1.) Do you have any disability insurance in force or pending (including group coverage)? ☐ YES ☐ NO
If "Yes," please indicate companies and amounts:

2.) Will this coverage applied for replace any insurance now in force? ☐ YES ☐ NO
If "Yes," please indicate which insurance and the amount being replaced:

6. Please read the following, then sign and date below to apply:

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY – I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the MIB Inc., formerly known as the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at any time by giving written notice to the Company. I agree that such revocation will not affect any action that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

IMPORTANT NOTICE – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

A copy of this application will be attached to and made a part of your certificate.

X	
Alumnus/Spouse's Signature	Date (MM/DD/YY)

G-19462-NY DI-RUT-NY Group Policy No. G-179,326 AG11904 (03/17) 06673611-1369 R03/17

License numbers: AR-100101639; CA Insurance License No. 0441679; MN-20270565; OK-100101074; TX-14468

Send no money now!

If you prefer to apply by mail, complete, sign, and mail this form to:
Willis Towers Watson • 6110 Parkland Boulevard • Cleveland, Ohio 44124
We'll send you a premium notice upon approval.

Or, you can fax your completed application to:
Willis Towers Watson at 973-410-4600. Questions? Call 1-800-343-5433.

MIB Disclosure Notice (Retain for Your Records)

Information regarding your insurability will be treated as confidential. The United States Life Insurance Company in the City of New York or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The United States Life Insurance Company in the City of New York, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Note: Canadian Members should continue to use the following address: 330 University Avenue, Suite 501, Toronto, Ontario, Canada, M5G 1R7, tel. no. 416-597-0590.

MIB-19431

NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(s)

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such a consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.

FCRA-19432